Archwilio Cymru
Audit Wales

Discharge Planning Progress Update – Hywel Dda University Health Board

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Summary report

About this report

1 In 2017, the Auditor General reviewed discharge planning across all health boards in Wales. That work focused on strategic planning, arrangements for monitoring and reporting on discharge planning, and action being taken to manage discharge planning and secure improvements.

2 Our 2017 report on discharge planning for Hywel Dda University Health Board (the Health Board) found that there was **"some improvement in key performance measures but it will be some time before initiatives to improve discharge planning and patient flow take full effect'**. We made several recommendations for the Health Board to address.

3 The Auditor General has been undertaking a programme of work across Wales which has examined whole system issues affecting urgent and emergency care services. This has included a review of health boards' and local authorities' arrangements to ensure the timely discharge of patients out of hospital. The findings from this work in the West Wales region are set out in a separate report to the Health Board and its local authority partners. The regional report will be made available on our website once considered by the appropriate Health Board and local authority committees.

4 As part of our regional review, we have also looked to assess the progress made by the Health Board in addressing the recommendations set out in our 2017 discharge planning report. This report sets out the findings with respect to progress against the recommendations. The approach we adopted to deliver our work is set out in **Appendix 1**.

5 The Auditor General's work on urgent and emergency care aims to help discharge his statutory duty to be satisfied that NHS bodies and local authorities have proper arrangements in place to secure efficient, effective, and economical use of resources..

6 To support our previous work on discharge planning, we produced 'What's the hold up? Discharging patients in Wales' which sets out important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways. Many of the issues identified are still relevant and should be considered alongside the findings of this report.

Key findings

7 Data from April 2025 showed that across the Health Board's main hospital sites, there were 222 patients whose discharge had been delayed beyond 48 hours. Approximately 26% of these delays related to discharge planning issues within the Health Board, including the completion of clinical assessments.

8 In overall terms, the Health Board has made slow progress in addressing the previous recommendations we made in 2017 to help improve discharge planning.

Our 2017 report made six recommendations that set out 12 specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, our follow up work found that:

- no progress has been made against four of the actions;
- work is still on-going against four of the actions;
- one of the actions has been superseded by other developments;
- three of the actions have been implemented.

9 Specifically, our follow up work found that:

- until recently the Health Board has lacked an organisation-wide discharge policy. A new policy was launched in 2025 which covers many of the areas we previously raised as well as how performance will be monitored.
- there has been no consistent approach to discharge planning training within the Health Board or in partnership with local authority colleagues, although training is now planned as part of the rollout of the new discharge policy.
- there is an inconsistent approach to the use of discharge lounges and limited monitoring of their impact to improve patient flow.
- performance reporting has changed significantly in line with new national models and programmes, and the Health Board's current arrangements for performance reporting are strong.
- since our original work the Health Board has implemented a digital platform to help better manage the discharge process, however, there have been issues with the accuracy of the information contained in the platform.

10 The following sections of the report set out our follow up findings in more detail and **Appendix 2** summarises our assessment of progress against each of the actions identified in our 2017 report.

Recommendations

11 Our follow up work and wider regional report on patient flow have identified two fresh recommendations on discharge planning for the Health Board, and where relevant, its local authority partners. These have replaced the outstanding recommendations from our 2017 work that are shown in **Appendix 2**.

12 The recommendation arising specifically from this follow up work is set out in **Exhibit 1**. The Health Board's response to this recommendation is captured in **Appendix 3**.

Exhibit 1: new recommendation arising from this follow up work

Recommendation
Improving use of discharge lounges R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.

Exhibit source: Audit Wales

13 The recommendation arising from our wider regional work on patient flow is set out in **Exhibit 2**. The Health Board's response to this recommendation is included in the regional report.

Exhibit 2: recommendation included in the regional report on discharge planning replacing previous 2017 recommendations

Regional recommendation
Developing and embedding policies R5 To embed a consistent approach to discharge planning, the Health Board and local authorities should ensure processes are in place to communicate the new discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis. Roll out of the guidance should be supported by an ongoing programme of refresher training and induction training for new staff

Exhibit source: Audit Wales

Detailed report

Implementation of previous audit recommendations

14 We considered the Health Board's progress in implementing our 2017 audit recommendations. These focus on:

- discharge and transfer of care policy (2017 Recommendations 1 and 2);
- training on discharge planning (2017 Recommendations 3a, b, c, and d);
- discharge lounge (2017 Recommendations 4a, b, c, and d); and
- performance reporting (2017 Recommendation 5); and
- performance monitoring (2017 Recommendation 6).

15 Overall, we found that **the Health Board has been slow to address our previous recommendations with a new discharge policy only recently approved. A new digital platform is now in place, with strong performance reporting but gaps remain in staff training and there is a need for more consistent use of discharge lounges across the Health Board.**

Discharge and Transfer of Care Policy

16 We considered whether the Health Board:

- in reviewing its discharge policy, has included:
  - the patient discharge leaflet;
  - the discharge pathways;
  - a discharge checklist;
  - reference or web links to the Home of Choice policy;
  - typical escalation procedures;
  - arrangements for patients discharged from A&E departments or medical/clinical assessment units; and
  - roles and responsibilities of ward staff (2017 Recommendation 1).
- has clear indicators for monitoring the impact of its discharge policy, which avoid duplication (2017 Recommendation 2).

17 We found that **until recently the Health Board has lacked an organisation-wide discharge policy. A new policy was launched in 2025 which covers many of the areas we previously raised as well as how performance will be monitored.**

18 The Health Board committed to a review of its discharge policy during May 2018. This did not happen and as a result different policy approaches were being used across the Health Board. Some sites were using the previously issued Welsh Government discharge policy and others were developing a standardised policy. Following a limited assurance Internal Audit review of discharge planning in 2024, the Health Board developed and approved an organisation-wide policy in April

2025. This builds on the updated Welsh Government discharge planning guidance first issued in September 2024.

19 The Health Board's policy covers many aspects of the good practice that we raised in our 2017 review. The policy now provides clear signposting to other relevant policies and information to support discharge planning. This includes patient information, and the care home of choice policy. The Health Board has also developed a Discharge Toolkit SharePoint page which brings together all relevant information in one place, improving access for staff. Discharge pathways have since been updated to reflect the national implementation of the Discharge to Recover and Assess (D2RA) policy, and these are referenced in the updated Welsh Government guidance. The roles and responsibilities of ward staff are also clearly set out in the Health Board's policy.

20 While there is reference to escalation, the policy does not clearly set out escalation procedures although it does refer to governance and escalation processes for delayed packages of care and discharges from acute settings in relation to Health Board roles and responsibilities. Overall, we consider **recommendation 1 has been substantially implemented,** although there is a need for the Health Board to set out arrangements for discharge from its emergency departments and assessment units in future iterations of the policy.

21 The Health Board's policy clearly sets out that it is the responsibility of the System Service Group Managers, in the new operational structure, to monitor performance associated with discharge, and the impact of the discharge policy. This includes reducing average length of stay, 'delayed transfers of care', bed capacity and patient flow. We consider **recommendation 2 has been implemented**,

Training on discharge planning

22 We considered whether the Health Board has:

- included training on discharge planning in induction programmes for staff who will be involved in making discharge arrangements (2017 Recommendation 3a);
- offered regular refresher training on discharge planning (2017 Recommendation 3b);
- explored opportunities for including the use of the Decision Support Tool in training on discharge planning (2017 Recommendation 3c); and
- provided simple guidance for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements (2017 Recommendation 3d).

23 We found that **there has been no consistent approach to discharge planning training within the Health Board or in partnership with local authority colleagues, although training is now planned as part of the rollout of the new discharge policy.**

24 Our review found that there has been an inconsistent approach to training within the Health Board, and a lack of joint training with relevant social service staff. We found that staff recognised that there are training requirements for everyone involved in discharge to better understand the process, and roles and responsibilities at each stage. For example, we heard how some patients are over promised packages of care by clinical staff which they may not get or need. This affects patient and family expectations which can delay patient discharge. Following the approval of the Health Board's new discharge policy in April 2025, the Health Board has set out its intentions to provide training to all healthcare professionals. We therefore consider that there is **ongoing action to address recommendations 3a and 3b.** We have however recommended in our regional review that training should also include social services staff **(replaced with 2025 Regional Recommendation 6).**

25 A reasonable assurance Internal Audit review of continuing healthcare arrangements in 2023 found that the Health Board has improved the use of the Decision Support Tool for the continuing healthcare funding process, with the tool completed appropriately in all samples of active care packages reviewed. The Health Board's new discharge policy refers to its continuing healthcare operational policy, which should be covered as part of its planned training. We therefore consider there is **ongoing action to address recommendation 3c (replaced with 2025 Regional Recommendation 6).**

26 Our review found that the use of agency nursing staff at the Health Board has reduced substantially since August 2024. In March 2025, the cost of agency nurse staffing accounted for 1.9% of the total nursing pay bill compared to 6.9% in August 2024. The use of bank staff however has increased, with the cost of bank nurse staffing accounting for 6.5% of the total nursing bill in March 2025. Training for bank and agency staff should be a key consideration of the Health Board's planned programme of communication and training following the approval of its new discharge policy. We therefore consider there is **ongoing action to address recommendation 3d (replaced with 2025 Regional Recommendation 6).**

Discharge lounges

27 We considered whether the Health Board has:

- actively promoted the use of discharge lounges (2017 Recommendation 4a);
- ensured patients being discharged are moved to discharge lounges as soon as they open (2017 Recommendation 4b);
- found out what prevents more patients being moved to the lounges on the day of discharge (2017 Recommendation 4c); and
- reviewed how long patients remain in discharge lounges to ensure the lounges do not get blocked with patients waiting to leave (2017 Recommendation 4d).

28 We found that **there is an inconsistent approach to the use of discharge lounges and limited monitoring of their impact to improve patient flow.**

29 Our review found that there was an inconsistent approach to the use of discharge lounges across the Health Board. Discharge lounges are located in Glangwili, Withybush and Prince Philip Hospitals. There is recognition in performance update reports that discharge lounges improve flow, but the Health Board lacks a corporate approach to ensuring they are used effectively. Our review also found limited evidence that discharge lounge activity is measured and monitored for impact. This means that opportunities are being lost to improve patient flow and free up beds. We therefore consider that **no action has been taken on recommendations 4a, 4b, 4c or 4d (replaced with 2025 Recommendation 1).**

Performance reporting

30 We considered whether the Health Board has included a summary of the impact of the unscheduled care campaign in the Integrated Performance Report in March 2018 (2017 Recommendation 5).

31 We found that **performance reporting has changed significantly in line with new national models and programmes, and the Health Board's current arrangements for performance reporting are strong.**

32 Since our original review, there have been several changes to the national guidance for urgent and emergency care, including the introduction of the Discharge to Recover then Assess (D2RA) model in 2018 and the introduction of the Six Goals for Urgent and Emergency Care Programme (Six Goals Programme) in 2021. The way performance is measured has also changed to align with these national policies and programmes.

33 Our recent review found that the Health Board has robust reporting and monitoring arrangements, aligned to the requirements of the Welsh Government's Six Goals Programme. Transforming Urgent and Emergency Care was one of the Health Board's Planning Objectives for 2024-25, which is monitored through the Strategy and Planning Committee. Progress against the Six Goals Programme is also monitored through the Health Board's Integrated Quality, Finance and Performance Delivery (IOFPD) mechanism set up in response to the Health Board's escalation status. Regular performance monitoring of urgent and emergency care indicators is also undertaken as part of the Integrated Performance and Assurance Report presented to the Board and the new Finance and Performance Committee[1]. We therefore consider **recommendation 5 has been superseded and can be closed.**

[1] Prior to 1st April, responsibility for oversight and scrutiny of performance was with the Strategic Development and Operational Delivery Committee.

Discharge information

34 We considered whether the Health Board has assessed if the patient administration system can be used to capture additional data items, such as whether a discharge is simple or complex and the date a patient is 'medically fit' for discharge (2017 Recommendation 6).

35 We found that **since our original work the Health Board has implemented a digital platform to help better manage the discharge process, however, there have been issues with the accuracy of the information contained in the platform.**

36 Since our 2017 review, the Health Board has implemented 'Frontier', a digital discharge platform which enables patient details, including an expected date of discharge to be recorded. Simple and complex discharges are now captured through the allocation of the relevant D2RA pathway category. However, the limited assurance Internal Audit review of discharge planning in 2024 found that information contained within the Frontier system was often incomplete and inaccurate. The review found that the relevant D2RA pathway had not always been assigned, or was incorrect on the system, and the expected date of discharge was sometimes missing. The Health Board has since undertaken work to ensure that information contained on the Frontier system is accurate, with compliance reported at a ward level. Where compliance falls short, additional training is provided to relevant ward staff. We therefore consider **recommendation 6 has been implemented**.

Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. The methods formed part of the audit methods used to deliver our wider regional review.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers • Operational and strategic plans relating to urgent and emergency care • Updates on the six goals programme and urgent and emergency care to committees; and • Discharge procedure
Interviews	We interviewed the following: • Chief Operating Officer; • Deputy Director of Nursing; • Director of Primary Care, Community and Long-Term Care; • County Directors for Pembrokeshire, Ceredigion, and Carmarthenshire; • General Managers for Bronglais, Glangwili, and Withybush Hospitals; and • Programme Manager for Six Goals.
Observations	We observed Discharge Liaison Nurses at Glangwili and Withybush Hospitals.
Data analysis	We analysed StatsWales data. We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Element of audit methods	Description
Self-assessment	We asked the Health Board to complete and submit a self-assessment, setting out its view of progress against our 2017 recommendations.

Source: Audit Wales

Appendix 2

A summary of progress against our 2017 recommendations

Exhibit 4 sets out the recommendations we made in 2017 and our summary of progress

Recommendations	Progress
Discharge and Transfer of Care Policy R1 Our assessment of the Health Board's policy indicates that it could be strengthened when it is next scheduled to be reviewed and updated. The Health Board should include: • the patient discharge leaflet; • the discharge pathways; • a discharge checklist; • reference or web links to the Home of Choice policy; • typical escalation procedures; • arrangements for patients discharged from A&E departments or medical/clinical assessment units; and • roles and responsibilities of ward staff.	**implemented** – see paragraphs 18 - 20
Discharge and Transfer of Care Policy R2 One of the indicators for monitoring the impact of the policy is the percentage of patients discharged before 11 am, while the success of the SAFER patient flow model is assessed on discharging 33% of patients from inpatient wards before midday. The Health	**implemented** – see paragraph 21

Recommendations	Progress
Board should clarify whether the timeframe for the purpose of monitoring needs to be the same or different, and if so ensure the ability to monitor two separate indicators.	
Training on discharge planning R3 The Discharge and Transfer of Care Policy indicates that all frontline staff should have access to appropriate training. However, there is no regular training on discharge planning and its inclusion in induction programmes is inconsistent, while agency staff are unfamiliar with the discharge process. Meanwhile, several staff felt more training is needed on the Decision Support Tool for the continuing healthcare funding process, which would, in turn, inform discharge planning arrangements. The Health Board should: a) include training on discharge planning in induction programmes for staff who will be involved in making discharge arrangements; b) offer regular refresher training on discharge planning; c) explore opportunities for including the use of the Decision Support Tool in training on discharge planning; and d) provide simple guidance for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements	**ongoing** – see paragraph 24 **ongoing** – see paragraph 24 **ongoing** – see paragraph 25 **ongoing** – see paragraph 26 (Replaced with 2025 Regional Recommendation 6)
Discharge lounges R4 Discharge lounges appear to support fewer patients than might be expected given their overall capacity and operational hours. Meanwhile, some patients are waiting 12 or more hours overnight in A&E until beds become available. The Health Board should: a) actively promote the use of the discharge lounge; b) ensure patients being discharged are moved to the discharge lounge as soon it opens;	**no action** – see paragraph 28 **no action** – see paragraph 28

Recommendations	Progress
c) find out what prevents more patients being moved to the lounge on the day of discharge; and	**no action** – see paragraph 28
d) collate information on the length of time patients remain in the discharge lounge before leaving the hospital to assess whether slow turnover is preventing patients from being moved to the lounge on the day of discharge	**no action** – see paragraph 28 (Replaced with 2025 Recommendation 1)
Performance reporting R5 The Health Board has recently launched its unscheduled care campaign. The Health Board should include a summary of the impact of the campaign in the Integrated Performance Report in March 2018.	**superseded** – see paragraphs 32 - 33
Discharge information R6 The patient administration system does not capture data items that could support monitoring and reporting of compliance with discharge standards and policies. The Health Board should assess if the patient administration system can be used to capture additional data items, such as whether a discharge is simple or complex and the date a patient is 'medically fit' for discharge.	**implemented** – see paragraph 36

Exhibit source: Audit Wales

Appendix 3

Management response to audit recommendations

Exhibit 5 sets out the Health Board's response to our audit recommendations.

Exhibit 5: management response

Recommendation	Management response	Completion date	Responsible officer (title)
R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved	We currently have active discharge lounges in three of our four acute hospitals. **PPH – Open 8am – 6pm (Mon to Fri) -** The opening hours in PPH have been extended from 10am to 6pm following the recommendations set out within this audit. **GGH – Open 8am – 6pm (Mon to Fri)** **WGH – Open 9am – 6pm (Mon to Fri) -** Ongoing plans to extend the opening hours from 8am in line with the Carmarthenshire sites. **BGH** – No current provision due to availability of space. Following a series of fire safety work scheduled over the coming months, a location has been identified to use as a discharge lounge facility. As an interim solution, staff are being actively encouraged to follow discharge lounge protocols by identifying suitable spaces within the ward environment where patients who can sit out are transferred from their bed space on the morning discharge while final arrangements and transport are completed.	Complete	Assistant Director of Nursing (Community and Integrated Medicine Clinical Care Group)

Recommendation	Management response	Completion date	Responsible officer (title)
to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.	On the week commencing 8 September 2025, we are undertaking a 'reset week' with a focus on patient flow, processes and discharge. An element of this exercise is to concentrate on increasing the number of patients being discharged before midday, supported using our discharge lounges. The targeted approach will enable us to capture and develop criteria for patients suitable for transfer to the discharge lounge alongside some of the perceived constraints in relation to this.	October 2025	Assistant Director of Nursing (Community and Integrated Medicine Clinical Care Group)
	Historically, it has been believed that for a patient to be conveyed to a discharge lounge that all elements of the discharge checklist must be complete and the discharge lounge is a waiting room for transport only. We have commenced a significant amount of training pertaining to discharge to culturally influence and develop professional understanding, accountability and ownership. Specifically, this training includes Discharge to Recover and Assess alongside Criteria Led Discharge. Our training percentage is currently demonstrating low compliance in these areas; therefore, the target is to reach a minimum of 80% within our registered nurses and Allied Health Professional workforce.	March 2026	Assistant Director of Nursing (Community and Integrated Medicine Clinical Care Group)
	The Health Board has recognised that there is a requirement for a competency profile review for nursing staff working in our discharge lounges to enable patients that require final clinical interventions to have these completed in the discharge lounge. Examples of these competencies include dressings and IV administration.	December 2025	Assistant Director of Nursing (Community and Integrated Medicine Clinical Care Group)
	Our SharePoint page now holds a toolkit specifically appropriate to hospital discharge. This includes an individual page holding a suite of information concerning discharge lounges. Relevant	October 2025	Assistant Director of Nursing

Recommendation	Management response	Completion date	Responsible officer (title)
	documentation is accessible from this area and includes forms such as an SBAR transfer document that aims to facilitate and expedite the transfer in a safe and efficient manner. A Welsh PAS transfer to discharge guide also simplifies the process for updating the patient location in a timely approach. Using this data will be conducive to our ongoing monitoring of discharge lounges and the amount of time that patients remain there. This is already embedded as a requirement for the transferring ward however closer monitoring and review will ensure compliance.		(Community and Integrated Medicine Clinical Care Group)

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